

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

20951  
2149

**1. PLACE OF DEATH**

County \_\_\_\_\_ Registration District No. F 791  
Township \_\_\_\_\_ Primary Registration District No. 1003  
City St. Louis Mo (No. 4247) Swan Ave St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 5768.  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Amalia Doering  
(a) Residence. No. 4247 Swan Ave St. 18 Ward. \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Hugo Doering

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 19 - 1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
63 5 22

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) at Home  
(c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Germany

**10. NAME OF FATHER**

George Maier

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Germany

**12. MAIDEN NAME OF MOTHER**

Amalia

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Germany

**14.**

INFORMANT Hugo Doering  
(Address) 7614 Swan Ave

**15.**

JUN 14 1930  
FILED \_\_\_\_\_ 19 \_\_\_\_\_  
REGISTRAR \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 11 1930

17. I HEREBY CERTIFY, That I attended deceased from May 28 1930 to June 11 1930 that I last saw her alive on June 11 1930 and that death occurred, on the date stated above, at 10 a.m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Bronchial Asthma non tubercular  
92B

117 (duration) 1 yrs. 6 mos. 0 ds.  
CONTRIBUTORY Mitral Insufficiency  
(SECONDARY)

unknown (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

at place of death  
IF NOT AT PLACE OF DEATH: \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) Wmarr Sherman M. D.

, 19 (Address) 4260 Manchester Ave

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

**DATE OF BURIAL**

Valhalla Crematory June 14 1930

**20. UNDERTAKER**

**ADDRESS**

Wmarr Sherman & Co 4234  
Manchester Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

